

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Registration District No. **677**

Primary Registration District No. **4403**

Registrar's No. **133**

1. PLACE OF DEATH:
 (a) County Phelps
 (b) City or town Rolla, Mo.
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Janae Gibson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 0
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 26 1941
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 8 _____ hr. _____ min.

9. Birthplace Rolla Mo 11
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Ted Gibson
 13. Birthplace Granite, Okla. 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Edith Hunter
 15. Birthplace Cuba Mo 0
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edith Hunter
 (b) Address Rolla Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5, 1941
 (Month) (Day) (Year)
 (c) Place: burial or cremation Oak Ridge, Cuba Mo

18. (a) Signature of funeral director Mrs Harry McGow
 (b) Address Rolla Mo

19. (a) Oct 5, 1941 (Date received local registrar) (b) Joe F. Myers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Phelps
 (c) City or town Rolla, Mo 2
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5 year 1941 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from Oct 4 to Oct 5, 1941, that I last saw her alive on Oct 5, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 3 day
 Duration

Due to _____
 Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature William H. Brewster (M. D. or other) 10/6/41
 Address St James Mo Date signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39897
Registrar's No.

Registration District No. 127

Primary Registration District No. 4413

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Phelps
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or (days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jane Gibson

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 26 1914
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Whooping Cough _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signatur William H. Butler (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

5-39097